		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0024463

Facility Name: PETERSON PARK HEALTH CARE CENTER

Address: 6141 N. PULASKI (Number) CHICAGO (City) 60646 (Zip Code)

County: COOK

Telephone Number: (773) 478-2000 **Fax #** (773) 478-8408

IDPA ID Number:

Date of Initial License for Current Owners: 01/01/78

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Bob Kagda **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS LTD., 3750 W DEVON AVE , LINCOLNWOOD, IL 607122-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	93	Skilled (SNF)	93	33,945	1
2		Skilled Pediatric (SNF/PED)			2
3	95	Intermediate (ICF)	95	34,675	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	188	TOTALS	188	68,620	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	29,103		2,435	31,538	8
9	SNF/PED					9
10	ICF	18,504	3,810	90	22,404	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,607	3,810	2,525	53,942	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.61%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/78

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 17 and days of care provided 2,435

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTI # 0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	287,186	31,032	22,298	340,516		340,516		340,516			1
2	Food Purchase		302,439		302,439	(29,858)	272,581	(208)	272,373			2
3	Housekeeping	137,041	29,243		166,284		166,284		166,284			3
4	Laundry	57,024	11,959		68,983		68,983		68,983			4
5	Heat and Other Utilities			123,798	123,798		123,798	4,276	128,074			5
6	Maintenance	101,390		95,918	197,308		197,308	2,793	200,101			6
7	Other (specify):*											7
8	**TOTAL General Services**	582,641	374,673	242,014	1,199,328	(29,858)	1,169,470	6,861	1,176,331			8
	B. Health Care and Programs											
9	Medical Director			15,600	15,600		15,600		15,600			9
10	Nursing and Medical Records	2,051,718	127,417	20,067	2,199,202		2,199,202	(19,260)	2,179,942			10
10a	Therapy		188	4,919	5,107		5,107		5,107			10a
11	Activities	177,716	23,605	3,158	204,479		204,479		204,479			11
12	Social Services	298,572		7,130	305,702		305,702		305,702			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,528,006	151,210	50,874	2,730,090		2,730,090	(19,260)	2,710,830			16
	C. General Administration											
17	Administrative	149,489		423,449	572,938		572,938	(353,309)	219,629			17
18	Directors Fees											18
19	Professional Services			87,229	87,229	(23,000)	64,229	1,191	65,420			19
20	Dues, Fees, Subscriptions & Promotions			108,999	108,999		108,999	(72,863)	36,136			20
21	Clerical & General Office Expenses	73,759	31,340	271,892	376,991		376,991	8,746	385,737			21
22	Employee Benefits & Payroll Taxes			538,994	538,994	29,858	568,852	17,350	586,202			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,283	4,283		4,283	(336)	3,947			24
25	Other Admin. Staff Transportation			213	213		213	2,749	2,962			25
26	Insurance-Prop.Liab.Malpractice			119,821	119,821		119,821	4,202	124,023			26
27	Other (specify):*							237	237			27
28	**TOTAL General Administration**	223,248	31,340	1,554,880	1,809,468	6,858	1,816,326	(392,033)	1,424,293			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,333,895	557,223	1,847,768	5,738,886	(23,000)	5,715,886	(404,432)	5,311,454			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER #0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			190,193	190,193		190,193	14,968	205,161			30
31	Amortization of Pre-Op. & Org.			3,887	3,887		3,887		3,887			31
32	Interest			69,562	69,562		69,562	7,949	77,511			32
33	Real Estate Taxes			185,731	185,731	23,000	208,731	8,837	217,568			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,304	1,304		1,304	5,794	7,098			35
36	Other (specify):*											36
37	**TOTAL Ownership**			450,677	450,677	23,000	473,677	37,548	511,225			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		107,463	82,359	189,822		189,822		189,822			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			102,930	102,930		102,930		102,930			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		107,463	185,289	292,752		292,752		292,752			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,333,895	664,686	2,483,734	6,482,315		6,482,315	(366,884)	6,115,431			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(472)	30		9
10	Interest and Other Investment Income	(10)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(208)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(671)	21		18
19	Entertainment				19
20	Contributions	(7,550)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,353)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(164,942)	21		24
25	Fund Raising, Advertising and Promotional	(66,732)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(180)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(30,718)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (272,836)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(94,048)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (94,048)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (366,884)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

PETERSON PARK HEALTH CARE CENTER

ID# 0024463

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Veterans Exp	$ (19,260)	10	1
2	Theft Loss	(622)	21	2
3	Unexpliained seminars	(336)	24	3
4	KBKB	(10,500)	19	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(30,718)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(208)	0	0	0	0	0	0	0	0	0	0	(208)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	4,276	0	0	0	0	0	0	0	0	4,276	5
6	Maintenance	0	0	2,793	0	0	0	0	0	0	0	0	2,793	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(208)	0	7,069	0	0	0	0	0	0	0	0	6,861	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(19,260)	0	0	0	0	0	0	0	0	0	0	(19,260)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(19,260)	0	0	0	0	0	0	0	0	0	0	(19,260)	16
	C. General Administration													
17	Administrative	0	0	(358,509)	5,200	0	0	0	0	0	0	0	(353,309)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(11,853)	0	13,044	0	0	0	0	0	0	0	0	1,191	19
20	Fees, Subscriptions & Promotions	(74,282)	0	1,419	0	0	0	0	0	0	0	0	(72,863)	20
21	Clerical & General Office Expenses	(166,415)	0	175,161	0	0	0	0	0	0	0	0	8,746	21
22	Employee Benefits & Payroll Taxes	0	0	17,350	0	0	0	0	0	0	0	0	17,350	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(336)	0	0	0	0	0	0	0	0	0	0	(336)	24
25	Other Admin. Staff Transportation	0	0	2,749	0	0	0	0	0	0	0	0	2,749	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,202	0	0	0	0	0	0	0	0	4,202	26
27	Other (specify):*	0	0	0	237	0	0	0	0	0	0	0	237	27
28	**TOTAL General Administration**	(252,886)	0	(144,584)	5,437	0	0	0	0	0	0	0	(392,033)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(272,354)	0	(137,515)	5,437	0	0	0	0	0	0	0	(404,432)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(472)	0	15,440	0	0	0	0	0	0	0	0	14,968	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10)	0	7,959	0	0	0	0	0	0	0	0	7,949	32
33	Real Estate Taxes	0	0	8,837	0	0	0	0	0	0	0	0	8,837	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	5,794	0	0	0	0	0	0	0	0	5,794	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(482)	0	38,030	0	0	0	0	0	0	0	0	37,548	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(272,836)	0	(99,485)	5,437	0	0	0	0	0	0	0	(366,884)	45

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Schedule attached		Courtyard Terrace (Endee)	Rockford			
		Embassy Care Cener	Willmington			
		Peterson Park Health Care	Chicago			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	$ 423,449	Future Associates		$	$ (423,449)	15
16	V	5	Utilities		Future Associates		4,276	4,276	16
17	V	6	Maintenance		Future Associates		2,793	2,793	17
18	V	17	Administrative		Future Associates		64,940	64,940	18
19	V	19	Professional Fees		Future Associates		13,044	13,044	19
20	V	21	Clerical and General		Future Associates		175,161	175,161	20
21	V	22	Employee Benefits		Future Associates		17,350	17,350	21
22	V	25	Auto Expense		Future Associates		2,749	2,749	22
23	V	26	Insurance Expense		Future Associates		4,202	4,202	23
24	V	30	Depreciation		Future Associates		15,440	15,440	24
25	V	32	Interest Expense		Future Associates		7,959	7,959	25
26	V	33	Real Estate Taxes		Future Associates		8,837	8,837	26
27	V	35	Equipment Rental		Future Associates		5,794	5,794	27
28	V	20	License, Dues, Fees		Future Associates		1,419	1,419	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 423,449			$ 323,964	$ * (99,485)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Salary Ron Shabat	$	Shabat & Associates		$ 55,200	$ 55,200	15
16	V	27	Payroll Taxes		Shabat & Associates		237	237	16
17	V	17	Management Fees (from Future)	50,000				(50,000)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 50,000			$ 55,437	$ * 5,437	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENT # 0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Ronald Shabat	Director	Administrative	39.00		30	55.00	Salary	$ 39,000	17-1	1
2	Nachshon Draiman	Director	Administrative	32.06				Allocated	55,200	17-7	2
3	Haim Perlstein	Director	Administrative	0.00		9	15.00	Allocated	64,940	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 159,140		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Future Associates
Street Address: 7514 N. Skokie Blvd
City / State / Zip Code: Skokie, Il
Phone Number: (847)982-1195
Fax Number: (847)982-0992

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Management Fees	991,241	4	$ 10,009	$	423,449	$ 4,276	1
2	6	Maintenance	Management Fees	991,241	4	6,537		423,449	2,793	2
3	17	Administrative	Direct allocation		4	149,601			64,940	3
4	19	Professional Fees	Management Fees	991,241	4	30,534		423,449	13,044	4
5	21	Clerical and General	Management Fees	991,241	4	353,538	253,435	423,449	151,028	5
6	22	Employee Benefits	Management Fees	991,241	4	36,129		423,449	15,434	6
7	25	Auto Expense	Management Fees	991,241	4	6,435		423,449	2,749	7
8	26	Insurance Expense	Management Fees	991,241	4	9,836		423,449	4,202	8
9	30	Depreciation	Management Fees	991,241	4	36,142		423,449	15,440	9
10	32	Interest Expense	Management Fees	991,241	4	18,631		423,449	7,959	10
11	33	Real Estate Taxes	Management Fees	991,241	4	20,687		423,449	8,837	11
12	35	Equipment Rental	Management Fees	991,241	4	13,564		423,449	5,794	12
13	20	License, Dues, Fees	Management Fees	991,241	4	3,321		423,449	1,419	13
14	21	Clerical and General	Direct allocation		4	43,880	43,830		24,133	14
15	22	Employee Benefits	Direct allocation		4	3,483			1,916	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 742,327	$ 297,265		$ 323,964	25

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Shabat & Associates
Street Address: 7514 N Skokie Blvd
City / State / Zip Code: Chicago, Il 60077
Phone Number: (847)-982-1195
Fax Number: (847)982-0992

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salary R Shabat	Avge hrs wkd.	55	3	$ 101,200	$ 101,200	30	$ 55,200	1
2	27	Payroll Taxes	Avge hrs wkd.	55	3	6,506		30	3,549	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 107,706	$ 101,200		$ 58,749	25

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTI # 0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Canada Life Insurance		X	Mortgage	$26,142.00	10/31/86	$ 2,300,000	$	11/01/01	11.0000	$ 14,119	1
2	Minolta Copier		X	Equipment Purchase		01/2000	21,285	1,005	01/05/02	18.3620	1,649	2
3												3
4												4
5												5
	Working Capital											
6	Success National Bank		X	Line of Credit				880,000		Various	51,432	6
7	Insurance Financing		X								2,362	7
8												8
9	TOTAL Facility Related				$26,142.00		$ 2,321,285	$ 881,005			$ 69,562	9
	B. Non-Facility Related*											
10	Allocation from Future										7,959	10
11	Interst Income										(10)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 7,949	14
15	TOTALS (line 9+line14)						$ 2,321,285	$ 881,005			$ 77,511	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$ 275,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 232,568	2
3. Under or (over) accrual (line 2 minus line 1).	$ (42,432)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 237,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$ 23,000	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 217,568	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	289,381	8
	1997	286,611	9
	1998	291,699	10
	1999	230,523	11
	2000	223,731	12
Adjust to 1.06% of 2000 bill		237000	
Allocation from Future 8837			

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PETERSON PARK HEALTH CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0024463

CONTACT PERSON REGARDING THIS REPORT Bob Kagda

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-02-115-052-000 318	Nursing Facility	$ 223,731.00	$ 223,731.00
2.	10-28-408-025	Management ofice	$ 19,875.47	$ 2,412.00
3.	10-28-408-026	Management ofice	$ 9,729.67	$ 1,181.00
4.	10-28-408-027	Management ofice	$ 9,729.67	$ 1,181.00
5.	10-28-408-028	Management ofice	$ 14,207.15	$ 1,724.00
6.	10-28-408-029	Management ofice	$ 14,207.15	$ 1,724.00
7.	10-28-408-030	Management ofice	$ 1,536.56	$ 186.00
8.	10-28-408-031	Management ofice	$ 1,535.56	$ 186.00
9.			$	$
10.			$	$
		TOTALS	$ 294,552.23	$ 232,325.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,900 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____
4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1986	$ 283,071	1
2					2
3	TOTALS			$ 283,071	3

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	188		1986		$ 2,548,850	$ 107052		$ 72824	$ (34,228)	$ 1098429	4
5	Alloc LCF		1986		92,846	3,899	30	3,095	(804)	46,681	5
6	Alloc LCF		1987		2,227	71	31.5	71		1,026	6
7											7
8											8
	Improvement Type**										
9	Various			1979	4,800		20			4,800	9
10	Various			1981	57,728		20			57,679	10
11	Various			1982	11,967		20			11,967	11
12	Various			1983	3,440		20			3,440	12
13	Various			1984	12,700		20			12,388	13
14	Various			1985	98,707		20	1,477	1,477	94,892	14
15	Various			1986	42,087	239	20	2,214	1,975	34,454	15
16	Various			1987	17,729	563	20	563		8,442	16
17	Various			1988	35,577	1,129	20	1,129		15,289	17
18	Various			1989	14,591	463	20	463		5,826	18
19	Various			1990	27,693	879	20	879		10,182	19
20	Various			1991	62,352	1,980	20	3,118	1,138	31,992	20
21	Various			1992	10,152	322	20	508	186	5,080	21
22	Various			1993	21,815	247	20	1,092	845	9,400	22
23	Various			1994	264,384	5,874	20	13,222	7,348	95,996	23
24	Various			1995	110,992	2,753	20	5,550	2,797	35,835	24
25	CUBICLE TRACK			1996	553	14	20	28	14	166	25
26	CCTV SYSTEM			1996	3,271	84	20	164	80	970	26
27	CCTV MONITOR			1996	1,085	28	20	54	26	319	27
28	ELECTRICAL LINE			1996	950	24	20	48	24	280	28
29	ELEVATOR ELECTRIC			1996	2,735	70	20	137	67	799	29
30	ROOF			1996	4,172	107	20	209	102	1,237	30
31	SHOWER STALLS			1996	3,000	77	20	150	73	863	31
32	CENTRAL A/C			1996	7,044	181	20	352	171	1,936	32
33	CCTV SYSTEM-TIME CLK			1996	1,126	29	20	56	27	303	33
34	FENCE			1996	1,675	104	20	84	(20)	441	34
35	BATHROOM VALVES			1996	3,950	101	20	198	97	1,056	35
36	NURSES CALL SYSTEM			1996	1,200	31	20	60	29	305	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DOOR & RAILINGS	1996	$ 1,850	$ 47	20	$ 93	$ 46	$ 473	37
38	FLUSH VALVES	1996	2,475	63	20	124	61	630	38
39	ROOF IMPROVEMT	1997	3,320	85	20	166	81	802	39
40	DOOR	1997	1,577	40	20	79	39	382	40
41	JACUZZI	1997	2,500	64	20	125	61	594	41
42	MISC IMPROVEMENTS	1997	2,700	69	20	135	66	619	42
43	BOILER	1997	3,846	99	20	192	93	864	43
44	VALVES	1997	2,300	59	20	115	56	508	44
45	ROOF IMPROVEMT	1997	4,340	111	20	217	106	940	45
46	DOORS	1997	35,052	899	20	1,753	854	7,596	46
47	TOILETS & VALVES	1997	1,250	32	20	63	31	268	47
48	DOORS	1997	2,090	54	20	105	51	446	48
49	ELEVATOR IMPROV	1997	3,000	77	20	150	73	638	49
50	DOORS	1997	975	25	20	49	24	204	50
51	New doors	1998	8,495	218	20	425	207	1,700	51
52	Smoke Dampers	1998	4,875	125	20	244	119	976	52
53	Bldg Renovaion	1998	1,383	35	20	69	34	270	53
54	Door locks	1998	6,655	171	20	333	162	1,249	54
55	Steel access panels	1998	2,881	74	20	144	70	528	55
56	Electrical Labor	1998	5,003	128	20	250	122	917	56
57	Roof Installation	1998	1,120	29	20	56	27	182	57
58	Seamless Gutters	1998	1,450	37	20	73	36	231	58
59	Solid core door	1998	710	18	20	36	18	114	59
60	Tuckpoint east wall	1998	3,100	79	20	155	76	478	60
61	Downspouts	1998	1,510	39	20	76	37	234	61
62	Double sliding door	1998	725	19	20	36	17	138	62
63	Roof North section	1998	660	17	20	33	16	129	63
64	Drywall and railings	1998	2,800	72	20	140	68	537	64
65	Hot water pump & Exh	1998	2,430	62	20	122	60	386	65
66	Door completion	1998	5,901	151	20	295	144	1,180	66
67	Door hinges	1999	1,402	36	20	70	34	204	67
68	220V FOR FREEZER	1999	500	13	20	25	12	75	68
69	Circular Pump	1999	4,738	121	20	237	116	711	69
70	TOTAL (lines 4 thru 69)		$ 3,595,011	$ 129,489		$ 113,930	$ (15,559)	$ 1,617,676	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,595,011	$ 129,489		$ 113,930	$ (15,559)	$ 1,617,676	1
2	WALLPAPER	1999	1,475	38	20	74	36	216	2
3	WALLPAPER	1999	1,535	39	20	77	38	225	3
4	FAUCETS	1999	1,941	50	20	97	47	275	4
5	KITCHEN EXHAUST	1999	999	26	20	50	24	133	5
6	THRESHOLD KITCHEN	1999	1,433	37	20	72	35	192	6
7	ARCHITECT-REMODEL	1999	1,700	44	20	85	41	227	7
8	NEW SOLENOID KIT	1999	390	10	20	20	10	53	8
9	NEW PIPE - HEATER	1999	249	6	20	12	6	32	9
10	NEW DOORS	1999	6,765	173	20	338	165	873	10
11	EJECTOR PUMP	1999	5,571	143	20	279	136	744	11
12	KITCHEN IMPROVEMENTS	1999	3,037	78	20	152	74	393	12
13	KITCHEN EXHAUST	1999	511	13	20	26	13	67	13
14	FRONT DOORS-THRESHLD	1999	1,421	36	20	71	35	183	14
15	ELECTRIC UPGRADE	1999	5,350	137	20	268	131	692	15
16	ROOF REPAIRS	1999	5,240	134	20	262	128	677	16
17	NEW SINKS	1999	2,500	64	20	125	61	323	17
18	WALL AIR COND	1999	2,344	60	20	117	57	293	18
19	HINGES,HANGER, ETC	1999	1,697	44	20	85	41	213	19
20	WALL AIR COND	1999	2,962	76	20	148	72	370	20
21	ROD OUT SEWER	1999	625	16	20	31	15	75	21
22	SEWER WORK	1999	3,395	87	20	170	83	411	22
23	EXIT DOOR ALARM	1999	700	18	20	35	17	85	23
24	WINDOW WELL COVERS	1999	1,646	42	20	82	40	191	24
25	KITCHEN FAUCETS	1999	1,081	28	20	54	26	126	25
26	FRONT CANOPY	1999	2,350	60	20	118	58	266	26
27	TANK PATCH	1999	1,167	30	20	58	28	131	27
28	CUBICLE CURTAINS	1999	1,261	32	20	63	31	163	28
29	ELECTRIC OUTLETS	1999	1,710	44	20	86	42	186	29
30	KITCHEN & lAB FAUCTS	1999	767	20	20	38	18	82	30
31	FIRE ALARM PANELS	1999	1,408	36	20	70	34	198	31
32	OUTLETS, WIRING	1999	733	19	20	37	18	111	32
33	WALL AIR CONDI.	1999	3,586	92	20	179	87	462	33
34	TOTAL (lines 1 thru 33)		$ 3,662,560	$ 131,221		$ 117,309	$ (13,912)	$ 1,626,344	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,662,560	$ 131,221		$ 117,309	$ (13,912)	$ 1,626,344	1
2	PULL HANDLE DOORS	1999	1,014	26	20	51	25	111	2
3	CUBICLE CURTAINS	1999	1,237	32	20	62	30	145	3
4	CORNICES	1999	20,381	523	20	1,019	496	2,463	4
5	Fire suppression sys	2000	2,058	53	20	103	50	180	5
6	A/C thermostadt	2000	4,604	118	20	230	112	403	6
7	Air conditioneers	2000	3,646	93	20	182	89	303	7
8	Air conditioneers	2000	4,311	111	20	216	105	306	8
9	Dual pres. control	2000	703	18	20	35	17	70	9
10	Rehung Door closers	2000	1,183	30	20	59	29	118	10
11	Enviormnt testing	2000	1,445	37	20	72	35	138	11
12	1 htgValves"	2000	556	14	20	28	14	54	12
13	Door Hldr, Ball bear	2000	1,130	29	20	57	28	105	13
14	Valves,ovrhd pipe	2000	1,997	51	20	100	49	183	14
15	3 grease traps	2000	7,345	188	20	367	179	673	15
16	Repair rehang door	2000	1,578	40	20	79	39	138	16
17	SS Panel	2000	372	10	20	19	9	30	17
18	New gas line	2000	875	22	20	44	22	70	18
19	Install door frames	2000	4,150	106	20	208	102	277	19
20	Door closers	2000	1,435	37	20	72	35	108	20
21	Vinyl floor tile	2000	566	15	20	28	13	40	21
22	New elect pipe wire	2000	1,300	33	20	65	32	92	22
23	Repair A/C lines	2000	2,804	72	20	140	68	198	23
24	Rebult lift assemb	2000	557	14	20	28	14	37	24
25	Repair dining door	2000	481	12	20	24	12	32	25
26	Replace shower fauct	2000	2,800	72	20	140	68	175	26
27	Door closures	2000	1,213	31	20	61	30	71	27
28	Kitchen exhaust fan	2000	772	20	20	39	19	46	28
29	Probes for tank	2000	567	15	20	28	13	30	29
30	Borders Resident rm	2000	7,600	195	20	380	185	412	30
31	Borders resident rm	2000	637	16	20	32	16	35	31
32	Det Heat 194F	2000	1,121	29	20	56	27	112	32
33	Repair oven doors	2000	691	18	20	35	17	64	33
34	TOTAL (lines 1 thru 33)		$ 3,743,689	$ 133,301		$ 121,368	$ (11,933)	$ 1,633,563	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,743,689	$ 133,301		$ 121,368	$ (11,933)	$ 1,633,563	1
2	Templer sprink.syst	2000	1,609	41	20	80	39	113	2
3	Light fixtures	2000	22,067	566	20	1,103	537	1,746	3
4	Ceiling Dining room	2000	20,041	514	20	1,002	488	1,336	4
5	Wallpaper	2000	683	18	20	34	16	43	5
6	Lobby baseboard	2000	1,437	37	20	72	35	90	6
7	New ceilings	2000	11,027	283	20	551	268	751	7
8	Wall - Employee DR	2000	2,411	62	20	121	59	141	8
9	Flooring, Wallcover	2000	63,063	1,617	20	3,153	1,536	4,992	9
10	New Ceiling, Fixture	2000	6,205	159	20	310	151	465	10
11	HOT WATER HTR	2001	1,100	27	20	55	28	55	11
12	VALVES,PUMP,A/C	2001	1,218	25	20	51	26	51	12
13	AIR COND	2001	3,324	46	20	97	51	97	13
14	STOREROOM LOCK	2001	937	3	20	8	5	8	14
15	EXHAUST FAN	2001	1,675	2	20	7	5	7	15
16	NEW ROOFTOP KIT. FAN	2001	880	1	20	4	3	4	16
17	REPAIR NSE CALL SYS	2001	715	1	20	3	2	3	17
18	PILOT SAFETY CONTROL	2001	1,514	2	20	6	4	6	18
19	ENERGY MGMT CONTROL	2001	1,975	2	20	8	6	8	19
20	BATH TUB FAUCETS	2001	3,450	62	20	130	68	130	20
21	HANDLE STOPPER	2001	625	11	20	23	12	23	21
22	DOOR CLOSE	2001	607	11	20	23	12	23	22
23	KEY & CYLINDERS	2001	1,348	28	20	56	28	56	23
24	ALARM CONTROL	2001	1,880	30	20	63	33	63	24
25	NEW LAV FAUCETS	2001	625	10	20	21	11	21	25
26	WALLPAPER	2001	7,508	185	20	375	190	375	26
27	WALLCOVERINGS	2001	11,626	236	20	484	248	484	27
28	BROKEN SEWER LINE	2001	1,400	20	20	41	21	41	28
29	WALKWAY,RETAIN. WALL	2001	2,590	30	20	65	35	65	29
30	AIR COND	2001	3,743	52	20	109	57	109	30
31	AIR COND	2001	3,027	42	20	88	46	88	31
32	WATER HEATER	2001	5,240	128	20	262	134	262	32
33	WINDOW TREATMENT	2001	1,536	28	20	58	30	58	33
34	TOTAL (lines 1 thru 33)		$ 3,930,775	$ 137,580		$ 129,831	$ (7,749)	$ 1,645,277	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,930,775	$ 137,580		$ 129,831	$ (7,749)	$ 1,645,277	1
2	TILES	2001	1,788	36	20	74	38	74	2
3	CCTV system repair	2001	2,967	29	20	62	33	62	3
4	Repair 6 sewerline"	2001	1,250	4	20	11	7	11	4
5	Floor tile	2001	2,290	52	20	105	53	105	5
6	Roofing	2001	895	7	20	15	8	15	6
7	Wallcoverings	2001	3,160	71	20	145	74	145	7
8	Tile	2001	513	4	20	9	5	9	8
9	CCTV repairs	2001	952	9	20	20	11	20	9
10	CCTV-reception desk	2001	1,560	8	20	20	12	20	10
11	Repair doors	2000	2,184	56	20	109	53	173	11
12									12
13	Allocation from LCF	1987	12,778	406	31.5	406		5,780	13
14	Allocation from LCF	1988	718	23	31.5	23		304	14
15	Allocation from LCF	1989	267	9	39	9		104	15
16	Allocation from LCF	1993	7,422	190	39	190		1,592	16
17	Allocation from LCF	1994	11,318	290	39	290		2,162	17
18	Allocation from LCF-Air Cond; Roof repairs	2001	3,152	39	39	39		39	18
19	Allocation from Future	1987	40,271	1,279	31.5	1,279		19,338	19
20	Allocation from Future	1994	11,778	160	Various	715	555	5,636	20
21	Round off adj			(2)			2		21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,036,038	$ 140,250		$ 133,352	$ (6,898)	$ 1,680,866	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 580,748	$ 50,627	$ 58,727	$ 8,100	10	$ 322,115	71
72	Current Year Purchases	59,674	11,456	5,239	(6,217)	10	5,239	72
73	Fully Depreciated Assets	389,265	64	814	750		389,265	73
74								74
75	TOTALS	$ 1,029,687	$ 62,147	$ 64,780	$ 2,633		$ 716,619	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocation from Future			$ 62,384	$ 3,236	$ 7,029	$ 3,793	Var	$ 26,236	76
77										77
78										78
79										79
80	TOTALS			$ 62,384	$ 3,236	$ 7,029	$ 3,793		$ 26,236	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,411,180	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 205,633	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 205,161	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (472)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,423,721	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 1,304 Description: Postage meter
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocation from Future		$	$ 5,794	17
18					18
19					19
20					20
21	TOTAL		$	$ 5,794	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 32,641	$		$ 32,641	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			9,236			9,236	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			20,100			20,100	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				70,341		70,341	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39-2;39-3				20,382	37,122		57,504	13
14	TOTAL			$		$ 82,359	$ 107,463		$ 189,822	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

PETERSON PARK HEALTH CARE CENTER 0024463 01/01/01 to 12/31/01
Page16 Supplemnt

Special Services - Supplies - (Column 6 -Other)

1	Med Tube : Ent., & Urol	30430
2	Equipment Rental	6692
	Total	37122

Outside Therapies (Column 5- Other)

1	Respiratory Therapy	13838
2	Lab & XRay	6544
	Total	20382

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER **#** 0024463 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/01 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 404	$	1
2	Cash-Patient Deposits	56,962		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,490,433		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	75,578		6
7	Other Prepaid Expenses	1,681		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee advances	18,510		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,643,568	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	102,484		13
14	Buildings, at Historical Cost	2,548,850		14
15	Leasehold Improvements, at Historical Cost	1,145,871		15
16	Equipment, at Historical Cost	1,124,592		16
17	Accumulated Depreciation (book methods)	(3,416,654)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,505,143	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,148,711	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,369,086	$	26
27	Officer's Accounts Payable	66,145		27
28	Accounts Payable-Patient Deposits	52,161		28
29	Short-Term Notes Payable	880,000		29
30	Accrued Salaries Payable	453,974		30
31	Accrued Taxes Payable (excluding real estate taxes)	43,994		31
32	Accrued Real Estate Taxes(Sch.IX-B)	237,000		32
33	Accrued Interest Payable	4,417		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,106,777	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,005		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,005	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,107,782	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 40,929	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,148,711	$	48

***(See instructions.)**

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 243,612	1
2	Restatements (describe):		2
3	**Round Off adj.**	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 243,613	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(108,683)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(94,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (202,683)	17
	B. Transfers (Itemize):		
18			18
19	**Round Off adj.**	(1)	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (1)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 40,929	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,093,864	1
2	Discounts and Allowances for all Levels	(237,292)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,856,572	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	265,334	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 265,334	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	73,321	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	12,527	20
21	Other Medical Services	32,307	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 118,155	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental Schedule	133,561	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 133,561	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,373,632	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,199,328	31
32	Health Care	2,730,090	32
33	General Administration	1,809,468	33
	B. Capital Expense		
34	Ownership	450,677	34
	C. Ancillary Expense		
35	Special Cost Centers	189,822	35
36	Provider Participation Fee	102,930	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,482,315	40
41	**Income before Income Taxes (line 30 minus line 40)****	(108,683)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (108,683)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not completed If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

PETERSON PARK HEALTH CARE CENTER 0024463 01/01/01 to 12/31/01
Prior Period Adjustments

Page 19 - Line 28

Real Estate Taxes from non reimbursed years:	
1995	48,724
1996	47,968
Other	15,917
Inheritance proceeeds	20,952
Total	133,561

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,078	2,386	$ 82,206	$ 34.45	1
2	Assistant Director of Nursing	2,009	2,279	67,908	29.80	2
3	Registered Nurses	29,890	33,521	774,337	23.10	3
4	Licensed Practical Nurses	6,186	6,907	139,866	20.25	4
5	Nurse Aides & Orderlies	91,255	98,664	935,337	9.48	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	18,885	20,569	177,716	8.64	10
11	Social Service Workers	18,172	19,760	298,572	15.11	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,997	26,790	287,186	10.72	15
16	Dishwashers					16
17	Maintenance Workers	8,501	8,981	101,390	11.29	17
18	Housekeepers	15,903	17,524	137,041	7.82	18
19	Laundry	6,069	6,772	57,024	8.42	19
20	Administrator	5,025	5,249	149,489	28.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,595	7,106	73,759	10.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,883	3,279	52,064	15.88	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	238,448	259,787	$ 3,333,895 *	$ 12.83	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	507	$ 19,478	1-3	35
36	Medical Director	Monthly	15,600	9-3	36
37	Medical Records Consultant	40	1,959	10-3	37
38	Nurse Consultant	253	16,740	10-3	38
39	Pharmacist Consultant	Monthly	1,368	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	45	4,919	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	92	1,408	11-3	44
45	Social Service Consultant	159	7,130	12-3	45
46	Other(specify)				46
47	Purchasing Cons	Monthly	2,820	1-3	47
48	Religious Service	As required	1,750	11-3	48
49	TOTAL (lines 35 - 48)	1,096	$ 73,172		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ronald Shabat	Director	39%	$ 39,000
Charlene Wells	Administrator		98,474
Menachem Shabat	Asst Adm		12,015
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 149,489

B. Administrative - Other

Description	Amount
Future Associates	$ 423,449
TOTAL (agree to Schedule V, line 17, col. 3)	$ 423,449
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type		Amount
FR&R	Acctg.		$ 34,040
KBKB	Acctg.		21,000
L Cohn	Acctg.		3,196
Success National Bank	Bk Audit		1,200
Pollack & Weiss	Legal		23,000
Sachnoff & Weaver	Legal	adj	1,353
HowardPomper	Legal		700
Chgo Legal Aid	Legal		240
Professional Valuation	RE Appraisers		2,500
TOTAL (agree to Schedule V, line 19, column 3)			
(If total legal fees exceed $2500 attach copy of invoices.)			$ 87,229

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 51,845
Unemployment Compensation Insurance	23,387
FICA Taxes	254,207
Employee Health Insurance	133,390
Employee Meals	29,858
Illinois Municipal Retirement Fund (IMRF)*	
Chicago City Head Tax	7,656
Health & Welfare Fund	30,606
Employee Benefits	17,689
Employee Life Insuarance	3,667
Employee Education	2,225
Holiday Expense	14,322
Alloc from Future	17,350
TOTAL (agree to Schedule V, line 22, col.8)	$ 586,202

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,000
Advertising: Employee Recruitment	21,065
Health Care Worker Background Check	
(Indicate # of checks performed 67)	804
Ill Council LTC	10,528
Licenses & Fees	1,320
Advertising	66,732
Donations	7,550
Donations	(7,550)
Allocation from Future	1,419
Less: Public Relations Expense	( )
Non-allowable advertising	(66,732)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 36,136

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,947
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,947

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number PETERSON PARK HEALTH CARE CENTER # 0024463 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council Long Term Care--10528**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,434** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? **X** YES _____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **102,930**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **29,858** Has any meal income been offset against related costs? **No** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.